General Assembly

Raised Bill No. 411

January Session, 2015

LCO No. **2846**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING THE ACCREDITATION OF MANAGED CARE ORGANIZATIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (1) of subsection (a) of section 38a-478c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(1) (A) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but not be limited to: **[**(A)**]** (i) The ratio of the number of complaints received to the number of enrollees; **[**(B)**]** (ii) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; **[**(C)**]** (iii) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; **[**(D)**]** (iv) the number of utilization review determinations made by or on behalf of a managed care organization

not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; **[**(E)**]** (v) the percentage of those employers or groups that renew their contracts within the previous twelve months; and **[**(F)**]** (vi) notwithstanding the provisions of this subsection, on or before July first of each year, all data required by the National Committee for Quality Assurance **[**(NCQA)**]** for its Health Plan Employer Data and Information Set. **[**(HEDIS).**]** If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54.

(B) The commissioner shall find that the requirements of **[**this**]** subparagraph (A) of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance or the Accreditation Association for Ambulatory Health Care and has submitted the Health Plan Employee Data Information Set data required by subparagraph **[**(F)**]** (A)(vi) of this subdivision;

Sec. 2. Section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy or medical benefits plan, and each preferred provider network, as defined in section 38a-479aa, that contracts with a health care provider, as defined in section 38a-478, for the purposes of providing covered health care services to its enrollees, shall maintain a network of such providers that is consistent with the National Committee for Quality Assurance's network adequacy requirements**, [**or**]** URAC's provider network access and availability standards or the Accreditation Association for

Ambulatory Health Care's network adequacy standards.

Sec. 3. Subsection (b) of section 38a-478g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) Each managed care organization shall provide every enrollee with a plan description. The plan description shall be in plain language as commonly used by the enrollees and consistent with chapter 699a. The plan description shall be made available to each enrollee and potential enrollee prior to the enrollee's entering into the contract and during any open enrollment period. The plan description shall not contain provisions or statements that are inconsistent with the plan's medical protocols. The plan description shall contain:

(1) A clear summary of the provisions set forth in subdivisions (1) to (12), inclusive, of subsection (a) of this section, subdivision (3) of subsection (a) of section 38a-478c and sections 38a-478j to 38a-478*l*, inclusive;

(2) A statement of the number of managed care organization's utilization review determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure;

(3) A description of emergency services, the appropriate use of emergency services, including the use of E 9-1-1 telephone systems, any cost sharing applicable to emergency services and the location of emergency departments and other settings in which participating physicians and hospitals provide emergency services and post stabilization care;

(4) Coverage of the plans, including exclusions of specific conditions, ailments or disorders;

(5) The use of drug formularies or any limits on the availability of prescription drugs and the procedure for obtaining information on the availability of specific drugs covered;

(6) The number, types and specialties and geographic distribution of direct health care providers;

(7) Participating and nonparticipating provider reimbursement procedure;

(8) Preauthorization and utilization review requirements and procedures, internal grievance procedures and internal and external complaint procedures;

(9) The state medical loss ratio and the federal medical loss ratio, as both terms are defined in section 38a-478*l*, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut;

(10) The plan's for-profit, nonprofit incorporation and ownership status;

(11) Telephone numbers for obtaining further information, including the procedure for enrollees to contact the organization concerning coverage and benefits, claims grievance and complaint procedures after normal business hours;

(12) How notification is provided to an enrollee when the plan is no longer contracting with an enrollee's primary care provider;

(13) The procedures for obtaining referrals to specialists or for consulting a physician other than the primary care physician;

(14) The status of the National Committee for Quality Assurance **[**(NCQA)**]** <u>or the Accreditation Association for Ambulatory Health Care</u> accreditation;

(15) Enrollee satisfaction information; and

(16) Procedures for protecting the confidentially of medical records and other patient information.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2015*	38a-478c(a)(1)
Sec. 2	*October 1, 2015*	38a-472f
Sec. 3	*October 1, 2015*	38a-478g(b)

Statement of Purpose:

To add the Accreditation Association for Ambulatory Health Care as a recognized accreditation organization for managed care organizations in the state.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]